

**Application for License to  
Operate a Long-term Care Facility**

For Office Use Only  
Received 1/26/12  
Amount 1730.00

NF-1650.00  
PC 80.00

**I. IDENTIFICATION**

# 19322

Name Woodland Oaks Health Care Facility  
1820 Oakview Road  
Address \_\_\_\_\_  
City/County/Zip Ashland / Boyd / 41102  
606-325-5200  
Telephone number \_\_\_\_\_  
Administrator Kim Nall  
Date facility operation began at current address January 1994  
Date facility began operation under current owner January 1994

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<u>110</u>	_____
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

**II. CONTROL (check one in each column)**

State	<b>Profit X</b>	Individual
County	Nonprofit	Partnership
City		<b>Corporation XX</b>
<b>Private X</b>		

**II. OWNERSHIP**

Name and address of individual owner, partners or corporation. If partnership, list partners.  
Woodland Oaks Manor, LLC  
300 Provider Court, Suite 100  
Richmond, KY 40475

(OVER)

**RECEIVED**

**JAN 26 2012**

OFFICE OF INSPECTOR GENERAL

1/31

If facility owned or leased by a corporation, complete the following:

Name of corporation Woodland Oaks Manor, LLC  
Address of corporation 300 Provider Court, Suite 100, Richmond, KY 40475

Member Delbert Ousley

Member John D. Sword

Member Estate of Fred Nail

Treasurer \_\_\_\_\_

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility.

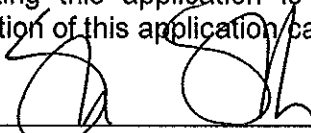
If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

Name and address of parent corporation and/or management company, if applicable.

Parent	Management Company
_____	<b>PMD Corporation</b>
_____	<u>300 Provider Court, Suite 100</u>
_____	<u>Richmond, KY 40475</u>

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

 _____	<u>V.P. Finance</u>	<u>1/12/12</u>
Signature of authorized representative	Title	Date

Return Application and fee to: Office of Inspector General  
275 East Main Street, 5E-A  
Frankfort, Kentucky 40621

OIG 5  
(10/2002)